

FSM Podcast - Episode Forty-Five – Flexibility

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[00:00:07] Hello.

[00:00:08] What's your theme for the week?

[00:00:12] Well, this is going to knock your socks off. Do you know what the theme of the week was going to be?

[00:00:18] Flexibility?

[00:00:20] Yes.

[00:00:21] Seriously?

[00:00:23] Yes.

[00:00:25] It's okay, because I have no. Yes.

[00:00:30] That's the reason why I didn't reply to your email when you said don't get attached to your ideas. And I was like, well, duh. Because it's all about being flexible.

[00:00:43] Yes. And you'll understand why I was. Thursday was a very interesting day. No, wait. Today's Wednesday. Monday.

[00:00:56] Last Thursday.

[00:00:59] Sometime. I have. I don't remember. They sort of blur inside there last Thursday or Friday. Or maybe it was Monday. Wasn't yesterday. Hey, it's me. You ready? All right.

[00:01:13] Remember the whole vagus nerve presentation on webinar? Remember the whole SIBO presentation where if you have SIBO, it's because your vagus isn't working and you don't have enough stomach acid. Remember that?

[00:01:28] Yes.

[00:01:29] And where? Esophagitis and digestion that doesn't work right. Is because you don't have enough stomach acid. Remember that whole. Elaborate 60 to 90-minute. Now we're going to treat the Vagus and you have to increase secretions in the Vagus. Remember that one? Where you had to put the pulse oximeter on and make sure that the pulse didn't go down too low. Remember that one.

[00:02:00] I do.

[00:02:01] Okay. Well. The first principle of science is you observe and then you verify and then you observe. And the second principle of science is you can't throw out the data because it doesn't agree with your model.

[00:02:17] Yes.

[00:02:18] Remember that.

[00:02:19] You do.

[00:02:20] Patient has digestive issues. Diagnosed with SIBO or something. Because if she eats almost anything, she'll belch. Start burping. And so that means the lower esophageal sphincter isn't doing what it's supposed to. And that means that she has the wrong gut bacteria. In my world that used to be because she didn't have enough stomach acid. But then the data that she presented was when I have this digestive crisis where I will set up belching, as she called it, belching, burping, belching, like catastrophically belching, for hours at a time while she's not sleeping. The way that she fixes it is Pepcid. And she said a tri salt. I said, let me see what's in the tri salt. Calcium carbonate. Magnesium carbonate. Some other carbonate. They're all really powerful anti-acids. And that stops your belching. Yeah. Yep. Then I can say. And it's like. She has too much stomach acid. Hmm. Okay. And then I took her pulse. And her pulse was

46. And she said, Well, it's always kind of low when I lay down. So I had her take sit up and it was 49. Pulse is too slow. You have too much stomach acid. I've never done this before, so it's entirely possible my head will fall off of the world, will come to an end.

[00:04:22] I'm not entirely sure which, but I ran concussion on one machine and then I ran 40/109 for the first time in my training Vegas career, and her pulse came up to 63. And she fell asleep and she felt really, really good.

[00:04:45] You can throw out the data because it doesn't match your model. So now that part of the Vegas presentation has got to go in the Advanced because by the time we get to the Vagus, the people in the Core are already not going to come. There's no room left. So in the Advanced, we have to have the conversation about; there is obviously at least one time and maybe more where you have to quiet the Vagus and her anxiety went down. Usually, that's a good face. Usually, when you increase secretions in the Vagus, it makes increases all the good things in the brain, which reduces anxiety and depression. Hope. Anxiety disappeared when I calm the Vagus. Which was really inconvenient because I didn't think it worked that way. So now I haven't had time to go and look through the, anything to find out that worked, how we did it, 40/89 and 40/94.

[00:06:01] And what's interesting is that all of this started after she had she broke her clavicle and she left side. And when she fell, it was a bicycle accident. Clavicle. And then she. Smacked her head this way. Then after she had the metal taken out of her clavicle, that made it even worse. So what runs right down here? So she had a traction injury. If you think about what happens when you have a traction injury to a regular nerve, it becomes hypersensitive. Right. And it doesn't work right? So. Apparently what happened was was her Vagus got stretched and became hypersensitive and you can't do a sensory exam on the Vagus. All you can do is look at what it does. And what it did was it made too much stomach acid that disturbs your bacterial flora. And made her anxious and made her heart rate 46. In the hospital if your heart rate goes to 46, the crash team comes in. In my office, I just ran 49. So that was the day that we really had a serious conversation about whether or not to have adult beverages in the clinic. You know, just for emergency purposes. Isn't that weird?

[00:07:54] I had to read your email quite a few times just to make sure that I was reading that right. Because. But you're right, you can't throw it out when it doesn't make sense.

[00:08:07] Well, you can't throw it out because it's not what you think it should be. Do you remember? I heard about somebody who was running 40/109 and I rolled my eyes and went, What are they thinking? Yeah, well, they're running 40/109 as a standard without checking the data. You can't run 40/89 on somebody with a pulse of 97. ErlosDanlos patients come in with a pulse of 97 and all the digestive issues and anxiety and depression and all those things. And for them, if you ran 40/89. So you can talk now because I just have to finish swallowing my foot.

[00:08:53] But you're not. And here's why you're not. And here's what I have to contribute to this. Because you have, especially in the last five years. Have been telling all of the disciples that we have to think about what we are doing. This isn't a list of recipes. This isn't a one size fits all. So you're not doing anything other than exactly what you're teaching us to all do is think about it and learn to adapt your frequencies, your thought process, your hypothesis on the fly.

[00:09:31] And on the basis of what you see.

[00:09:35] Right. What are your objective measures?

[00:09:40] Can I tell you one more story?

[00:09:42] Of course. Have a lot of time. At least you're doing this now, a few minutes in as opposed to at 4:59, which you normally do, but go.

[00:09:49] It's because this one was just. It. It was the ability to completely change a life in two days.

[00:09:58] Do it.

[00:10:00] So the lady came in and she said, Well, originally I was coming in. So she's a friend of Leif's and I hope Leif comes on so I can say hi. So he's a friend of Leif's and

she said, You have to go down and see her. She lives in Vancouver, B.C., so this is quite a trip. So she comes down and she said, Well, originally I came down because my thigh hurt because I fell, and now I'm just here for Achilles tendinopathy. Oh, okay. What? What do you do for a living? I'm a dental hygienist. Okay, so tell me about the fall, then she says. Oh, I fall a lot. Really? Well, what happened this time? Well, I missed the bottom stair. What? How? Tell me about. Tell me about missing the bottom stairs. So the lesson for today is ask open ended questions. Tell me about missing the bottom stair. Well, I didn't see it, and I thought I was on the bottom stair, and I. I thought I was down on the floor, but I missed the bottom stair. And then I fell on. I landed on my hip. So that's quite a crash. And the Achilles tendon myopathy was like, secondary. And I said. Tell me about falling. Why do you fall a lot? Well, I fall because I just. I just don't see right now. It can't be this easy.

[00:11:31] And I said, you know, the part of the history where you ask about trauma, she said, no, not much. Well, I did have a couple of auto accidents in my twenties. I said, Well, tell me about your auto accidents. Once again, open-ended questions. Tell me about your auto accidents. Well, the first one, she wasn't paying attention and she rear-ended somebody so whacko. Now, our neck has no pain, no pain, no hand pain. She ran somebody back in the day when they didn't have airbags. But then the next accident was she was going through a green light. Somebody ran the red and T-boned her at 30 miles an hour on the left side. And she said and then I was distracted by something. I ran a red light and somebody on the green came through and T-boned me again on the driver's side. And I went. So as I did the physical exam, I put the tuning fork here. She heard it equally in both ears. But something people shouldn't follow that often. And so I did the fields of gaze and she was psychotic in both directions. And I then I started asking that set of questions. And how do you do in Costco? I don't go to Costco. How about just busy places? I'm kind of guess that you shop at a really small grocery store and you avoid the big grocery store.

[00:13:19] Yeah. How about reading? Well, I have to read the same line three times. And then we went down that road. And how about sleeping? Well, I don't sleep very well. I haven't for years. Oh, how many years? She's 62. About 30 years. How old were you when the accident's happened? 29. So, you know, the BIVSS that 18-question questionnaire that Dr. Reski gave us? 18 is a predictive score, that they're going to have a problem. The highest BIVSS I've ever recorded was 38. So when I called and made

the appointment for her with Dr. Reski, I said, Oh, by the way, her BIFFF score is 88. And it's like; so that was the first day. I took two Meclizine out of my little pouch and I said, Take these 30 minutes before bed. Make sure you have a pillow against your back, pillow on your chest or on your tummy, and we had that conversation. She came in the next day. She said, I slept last night. I'm groggy today. All I want to do is go back to bed. And I said, Well, yeah, basically you haven't slept in 30 years, so your brain has an opinion about that. And then the first day this leg bruise thing. So the Achilles tendon was easy to fix, but. She said.

[00:15:19] And I have all this hip pain. So of course, I checked her abductors and pretentious because she felt really hard. Right? So there's scar tissue in the whole femoral plexus from her groin to her knee. So I started taking that apart and did 81/84 and 48, all of that. You would have been very proud and had her just lift her leg and internally and externally rotate her hip. And then she hadn't taken the Meclizine yet. And I wanted her to get on the reformer and use the leg. She walked in and looked at it and said, I can't do that. Okay. So the next day. Before I finished treating her, I gave her a Meclizine and finished treating all the scar tissue and did increase secretions in the cerebellum and introduced her left leg to her sensory and motor cortex. Went into the gym and put her on the reformer. With just half a spring. So that she can just get used to movement. And she said, that feels so good. Then we added another two springs like two. So now she's at two and a half springs. And as she moved, we had her engage her lumbar spine muscles and her abdominal muscles. And normally it's five reps and arrest and five reps and rest. She did 20 because she didn't want to stop and little rest. And and she wasn't dizzy.

[00:17:08] She could look at the ceiling and not have an anxiety attack. It entirely changed her life. She went to breakfast with people that she really enjoys, but as soon as she finished eating, she had to leave. It's like I can't say. And she didn't know why. She just thought she was a pathologic introvert. It's like, no, you just have had a brain and eye injury. And her optometrist put her in tri-focal progressive's. Okay. That's a good face. Try focal perspectives without doing fields of gaze. So that those were my those were mine. Well, there was another guy with the same thing. BIVSS. But this one was just miraculous. Her life completely changed. So she'll see Dr. Reski in. I think early September and see me in October. So now she's got two Meclizine at night one Meclizine in the morning. And get used to her life. In her brain and then she'll get prism

glasses and she has a month, so I won't see her again until October or early November is the first. So that was my week. But yeah, it's just. It's just my Achilles tendon. And then you ask, How did you fall? I. And then I fall a lot. Why do you fall? Well, I trip over things. Why do you do that? Well, I can't see them. Excuse me. I mean.

[00:19:18] So a lot to unpack here. That's I'm trying to take notes with your stories now because there's every little part is a note that we have to talk about.

[00:19:29] That just means that everybody who is a practitioner needs to. Keep a copy of the BIVSS in there.

[00:19:40] Okay, let's start there. Do you have a resource for this document so people can go to some place to get this document?

[00:19:48] At which point I will turn my head to the left and ask my resource guy. Do we have a place where we put the BIVSS? Because we had it with Reskis presentation?
But

[00:20:00] I'm not sure. Right. Any words generally. Okay.

[00:20:05] But if I send it to you, you can put it. Where could we put it?

[00:20:09] I need to think about that.

[00:20:11] Or we'll get back to everybody on that, because somebody I think written either to us directly or it was on a Facebook post.

[00:20:18] I'm going to say there's I think there's one in the in the documents on Facebook.

[00:20:23] Yes.

[00:20:24] And BIVSS stands for Brain Injury Visual System Symptom questionnaire. Jane, "B" is in boy. Brain Injury, "I". "V", visual system symptom questionnaire and Dr.

Reski is R, E, S, K, I and I honestly already have him booked out through half of September.

[00:20:58] Sorry about that.

[00:21:00] Yeah.

[00:21:02] We have to keep going with this story for a second.

[00:21:05] Yeah. Do your thing.

[00:21:07] It's not my thing.

[00:21:10] You have to fix it because I just.

[00:21:13] I just got to keep the train on the track. That's all I have to do. So otherwise, I don't know where you take the train. You put it in a tree, put it in a cloud. Okay. So the theme for this week I already had crafted I can show you my show notes for going through to September was flexibility. Now I have you ask 100 practitioners or definition of flexibility and we're all going to say something a little bit different, right?

[00:21:41] True.

[00:21:43] I will think about a muscle flexibility, a fascia flexibility. You could think of the flexibility of your mind. Right. This is kind of where we're going with the hypothesis first.

[00:21:53] Yep.

[00:21:54] So. Going back to. It's never just an Achilles tendonopathy. We all get that. I don't care. I don't care who you are or what you treat for your Cairo, M.D., whatever. Your patient is going to be attached to what they think it is, either because they Googled it, they thought of it, their neighbor told them, their medical doctor gave them a previous diagnosis.

[00:22:21] It was three physical therapists they saw, told them it was the glute medius and minimus when it was adhesions in the abductor which were internally rotating.

[00:22:33] Don't get me started on PTs and glute weaknesses because I need adult beverages in my mug to complete that conversation. I can get to that. So. So that's the first thing, right, patient? It's like the old joke, you know, like a cucumber walks into a bar, so your patient walks into your clinic, they're going to have it on their on their form. What they think their problem is, it is your job to glance at it, sidebar it, and continue on with whatever scope of practice you have. Now, one of the things, again, we're having this like rollercoaster of topics today. Somebody had, not wrote me hate email but was saying how overwhelmed they were because we make them feel as though they should know more than that is outside of their scope of practice. I'm going to get to that in a second. I get it. We have 1000 frequencies for 1000 different things. It is not your job to be able to diagnose or prescribe stuff that is outside of your practice. These are merely areas that you can refer to you're not expected to know or to deal with all the stuff that walks into your practice. Just because we told you there's a frequency for it.

[00:23:53] Oh, God, no. Right.

[00:23:55] So didn't think we had to say it out loud, but let's just say it out loud.

[00:23:58] Like this is all the time.

[00:24:02] Well, we got to say it louder for the folks in the back because somebody didn't hear it the right way. So this isn't to make anybody feel bad. There's so many different practitioners from so many different even just all PTs vary in their scopes of what they want to specialize in.

[00:24:21] So what they've been trained in and the thing that FSM does that is so unique in manual therapy, whether you're a PT, DO, what is that thing? Facial distortion model fashion is myofascial pain therapist. Whatever. FSM is gives you the answer to why. Yes, this patient had terrible trigger points and her glute medius and minimus, the external rotators. So where do you look if you're an FSM practitioner? If all you can do is put your thumb, elbow or needle into it, it's only the glute medius if you have FSM. It is, okay why is the medius so distressed that it got trigger points in it for the last however

long. Where do you go? It's an external rotator, but her hip, her femur is internally rotated. That means the gluteus, medius and minimus are, pissed off. Are hurting and developing trigger points because they're mechanically operating outside her scope. Right? With FSM, you have a way to check. Why is the femur internally rotated? Right. So you put your hands there and you think about what happens when a 230lb person steps off the step and lands. Just do the physics. You land from ten feet up on your left side and you're going to bleed in internally between the nerve and the fascia. That's not outside anybody's scope. No thinking is not outside the scope. So we have a tool that lets us. Oh, what I feel is adhesions between the nerve and the muscle. Well, she's been seeing a chiropractor that was treating those muscles, and it just hurts so much. She stopped. She said, Oh, that's really tender. So I switched to quiet the nerve. 40/396. Took the pain down. Then started treating for scar tissue. Got all that done. Got down to our knee. Ow. So back to it. So once we did that, then we could get the external rotation into her femur. Then I could put my thumb into her medius and minimus and it just went away.

[00:27:33] So I'm going to build on our questions.

[00:27:37] Go back to the skull.

[00:27:40] But when we teach the Core, when I teach the Sports, the slide that keeps repeating over and over again is what is wrong and where is that occurring? How? So we're going to go, right? Why? Right. So asking those open-ended questions, you have to treat every patient like you are a preschool teacher or daycare worker, and you're working with a temperamental three-year-old. You would never say, Oh, is this a tree that you drew? And the kid was like, No, that's my dad, you know, and runs off crying. You have to tell me about this picture. How did you come up with this concept? So like you were saying, tell me about your injury because. Saying I fell down the stairs or I fell off a curb or I just got in a motor vehicle accident isn't enough. How did the car come at you? What else was going on? You didn't mention that you had an infection after the surgery. There's all these things. So asking those open-ended questions is huge. You can also extract this way to the patients that don't talk about their feelings, a.k.a. athletes. You can extract emotional component nuggets when you ask them more about how was that? And then you'll hear them. It was really, really tough. I was really depressed after that happened. Or then my husband left me or my wife.

[00:29:13] And there's there's things that will happen when you ask. Tell me a little bit more about that and what else was going on during that time. So I think those are those are big things that I want to extract from your story, not getting attached to the diagnosis, not even getting attached to the imaging that comes in. And I know that seems weird because you would think that is an objective measure that is concrete. We can see what's happening. There's always more stuff in the onion than just the disk that exploded. The other question I want to add to this, instead of the how and the what and the why is what is going to make this condition worse? So when you are getting when you're in the weeds with something, with somebody that comes in with a very loaded history, or if you're under a lot of pressure to get an athlete back months ago, that is one of the things I've been starting to think about. What is going on? Where is it happening? How did it happen? But what could make this worse? So if you have a nerve that is scarred, what is going to make this worse? Well, stretching it too fast is going to make it worse. Being too aggressive with your treatment is going to make this worse.

[00:30:31] Or for the patient, what makes it better? What makes it worse is always the question. What makes it better? What makes it worse? So when I move it like this, it's like, okay, fine.

[00:30:44] Right. And then dissecting that, well, what is involved with that? This muscle has to contract. This muscle has to elongate what is the fascia look like? And that will help guide your frequencies as well. If stretching something to aggressively or moving something past a range of motion to aggressively is going to make it worse. Then gently dissolve the adhesions. Slowly, patiently, until the patient is able to complete that range of motion and is confident that they can do that range of motion. Now, I met a fabulous strength coach that I'm going to hopefully bring on at some point, that hit the nail. You know, when you talk to somebody and something just hits you right in the heart and you're just like, that is gold. We're talking about injuries with athletes and in a certain part of their rehabilitation when the pain is gone and the range of motion is symmetrical, this is the sweet spot. This is the hard part of rehab because there is no pain and they want to go back and they are not ready to go back yet because things are not done.

[00:32:04] Muscles that have been inhibited are weak. If they are tight, if they have trigger points in them and, you know, increase the range of motion, the muscles may go that far, but they're not strong in that in that position, they're not ready.

[00:32:24] Right. So do you know what this one's strength coach said? He's like, we have to treat this like a brain injury. And I was like, yes, that was my face. I'm like, Yes. Where have you been hiding? Like, this should be on a billboard somewhere because this is a brain injury and this is what we do.

[00:32:44] Tell me. He's an FSM practitioner.

[00:32:47] Not yet.

[00:32:48] You will be when you're finished with him if he starts with that mindset.

[00:32:51] Absolutely.

[00:32:52] There is a reason with this lady. So any time an area has been in pain for a period of time and it doesn't take long. The part of the sensory cortex that is devoted to that area gets bigger. So if you look at the homunculus in the sensory and motor cortex, the knee is kind of little. The feet and toes are big, the lips and face are huge, which is why injuries to the face are a big deal. But the knees like kind of little, the elbows little, the fingers are really big. But you put that knee in pain for, I don't know. I don't know how long that takes, but let's pretend that it's been in pain now for a month. And they finally, okay it's not going to get better by itself. I'm going to go see this lady. And when you treat the knee, as we know from Jay Shah and from everything else, that little diagram you have to treat from the low back to the knee. I talked about that last week. Well, back to the knee, but from the neck to the feet to quiet the spinal cord.

[00:34:19] 40/89 is quiet the midbrain and the thalamus. But the thalamus is the one that tells the sensory cortex this knee is a problem. So the first thing you have to do is turn down the sensory cortex, turn down the thalamus. So the two of them will stop talking about what a big, big problem than he is. And he goes back to a normal size. It's a brain injury. Yeah, because your knee hurts and then you quiet down the nerve and you're quiet on the court and you quiet down all that. And then you increase secretions

in the cerebellum, the cord and the nerve to get it moving right. But that isn't the end of the story until you then reintroduce... You dodge the thalamus, you just keep turning. You just be quiet. The knee's fine. Just go back to sleep. And then you increase secretions in the sensory cortex. And you say, sensory cortex, this is the new me. See, it doesn't hurt. And the sensory cortex says, Are you sure? Oh, yeah. Okay. And it reprograms really quickly, especially if you can get them in your world on a little flexible wall. In my world, get them on a reformer or...

[00:35:40] Yeah. One of the things that I've been playing with in shifting a little bit more is running 40/89 before they get off the table.

[00:35:51] Oh, absolutely.

[00:35:53] And I used to try to see it more organically without running it. And some people do they want to just pop off the table and they want to just show you everything, whether or not they're aware that the coordination is there is a whole other can of worms. So some people will be will verbally tell you, I don't like your patient, therefore I can't go on that. That's no problem. I'll say to some patients, let's retest. I don't want to I don't want to move it right now. Okay. You can't pressure somebody to go through an active range of motion. But what we do with dissolving adhesions and. It's not possible. We can't expect their nervous system to get that. That something that has been adhered for so long can soften and be pliable and flexible in smooshy within minutes.

[00:36:59] You have to treat the brain. It's like you really have to turn the thalamus down before they get off the table. And 20 years ago, even ten years ago, I never talked about that. So yesterday I was marveling or the day before I was marveling at what it was, how different my practice is when I have two CustomCare's, three PrecisionCare and an AutoCare just in case, but to CustomCare's in three precision cares and you can set one CustomCare just from 40/89. That's all it's going to do for 60-minutes. And it runs it the whole 60-minutes while you're working on it. So the thalamus has time to get used to it. Because the thalamus runs the show. There's no arguing with the midbrain. There's no arguing with the limbic system. It runs everything. All the trains go through the limbic system. Right. So you're right. He's right.

[00:38:08] Yeah. I just thought that was such a forward thinking, progressive way to talk to athletes without scaring them. Right? But to give them an appreciation for building your strength is all going to come from confidence of movement. And that is. Confidence of movement is going to be on my next set of t-shirts because, regardless if you're a professional athlete or, like I said, somebody who is learning how to walk again because of of an injury. It's the belief system that I can do this and do it well.

[00:38:47] I cheat. Are you ready? I don't even tell them. I don't even talk to them about it. They don't need to know because I have the ability to talk to their midbrain without getting their cortex involved. They don't need to know because they didn't know they were afraid to move it. They didn't know they were afraid to move it.

[00:39:13] Absolutely.

[00:39:14] And so you just.

[00:39:16] You just run it. Yeah. No, I'm not I'm not saying you have to to get into what you're treating. In fact, I don't think you should that would be almost outside of anybody's scope to say, I'm just going to treat your thalamus right now for inflammation. So if somebody ever said, that's just silly, right? We're trying to coordinate movement. It's just like putting on the CustomCare's when I prescribe it for patients, I'm not putting depression on there with the word depression. I'm I'll change the word depression to like neuro-com or like neuro-flex. I make up like makeup different words. You don't want. Even with that, right? With certain athletes, like concussion is the C-word. They don't want to hear that they've had one because they know if they have one more, they're forced into retirement. So change the name on the CustomCare. The software makes it very easy to do whatever you need to.

[00:40:12] And I call it concussion in Vagus, let's say, because that's what the practitioners are used to. But when I program it for a patient, I call it brain balance, right and wonder. And then the instructions that go with it are run this any time you've had a stressful day.

[00:40:30] Sure. Yeah.

[00:40:33] Yeah.

[00:40:33] Let's get to a question before we go too far. Alf wrote a big, long one.

[00:40:39] Oh.

[00:40:39] Do you want me to read it or do you want to read it? You go, Alf. He says, i just started working with the former elite Special Forces veteran, age 45 6'2", lean muscular build. He has an L-4, grade 2 spondylolithesis. Significant posterior disc bulges. L-3, L-4, L-5, S-1. Significant end plate disc generation between L-2-3

[00:41:03] Special Forces. Yeah. You know why? Alf,so think about the mechanism. These guys carry 50-60lb packs, and they run a lot while they're doing it with. If you've ever put on a put bulletproof vest, the darn thing weighs 30lbs. So they've got a pack in their back the with a vest. So they're probably carrying close to 80lbs and up. Maybe 100. I don't care how strong they are. So that's where all that came from. That's the mechanism.

[00:41:43] His pain can radiate to the right foot by ladder or bi lateral to knees and feet also has pain at times near the right ASIS. I think it's in the L-1 or 2 dermatome. Hyperesthesia left L-4 dermatome of foot and at the right L-5, S-1 dermatome on foot as well. Motor deficits 4 to 5 right vastness lateralizes L-3, L4. Left erroneous group aversion L5, S1. Posterior tib L-4, L-5. Three out of five bilateral toe flexors and extensors. Was possible association with severe flat foot prior to pain starting. Five out of five bilateral hamstring gastric anterior tibialis. He has wires in the chest secondary to open heart valve surgery. Partial left knee replacement. Prior to starting with FSM, I had him try Mackenzie lumbar flexion and range loading. It reduced the pressurization in his legs to some degree. I started with wraps around the neck in both feet. Customcare Lumbar pain protocol. PrecisionCare, 40/89 for 10 minutes, 40/10 for 20, and then torn and broken in the annulus for 12 to 15 minutes. Due to his work in distance from me. Only be seeing him once per week for a while. Please advise corrections or recommendations.

[00:43:06] Oc Do I get to vote? I get to do I get.

[00:43:10] I get you can and then I will.

[00:43:12] Okay, both of us. So if you're going to run the lumbar protocol, I'd go back and abdomen. So it goes through the disc and facets. When you look at. Or was it? It was. L-4. Great physical exam, by the way. Motor losses, so lots of neuropathic pain and that is low back to foot. So you have to treat the nerve with 40/396 is calm the inflammation down. So when you look at the disc bulges, they make sense just from the compression. But. L-1 or 2 because he has L-2-3 disc degeneration. You have to look at his psoas at some point when you get your hands on him. I'd go from his low back to his feet and his low back to his abdomen. So that's three machines right there. And then 40/10, that might be four machines. So low back in front. Low back to foot and wrap them kind of wrap the whole legs. You pick up everything from L-2-3-4-5, and S1.

[00:44:41] Did you see the bottom he just writes. Yes, you're correct about carrying weight. He was also in a helicopter crash.

[00:44:47] Oh, there you go. That's what I was looking for, some sort of compression injury with all those disc bulges, because he came out of the, you know, brain injury. BIVSS is good. Thank you, Jane. Where was the helicopter crash?

[00:45:05] It's the bottom after Jane's comment.

[00:45:07] Oh, there it is. Yep. Another helicopter crash. Okay, so let's compression. Yeah. This shouldn't be that hard. The problem he's going to have is, if what you do doesn't work, they're going to want to fuze everything from L1 to S1, and then he's really going to have problems. So this shouldn't be that hard. Treat from low back. So from back to front. For low back pain or straight up treating for discs while you go from low back to foot with the nerve 40/396 and then 81/396 after the pain is all gone and you get 81/396 will help get the motor back, quieten the spinal cord, that's another machine. So we now have one, two, three machines and neck to feet on 40/10. Neck to abdomen. I'd start with concussion and Vagus instead of PTSD because concussion and Vagus will take care of 40/89 and you can just bump the time from 4 minutes to 12 minutes.

[00:46:35] He writes that the crash happened while sitting. He's also run concussion. Va wants to do three fusions.

[00:46:41] Yeah, that's. I told you, I hate it when I'm right. Yeah.

[00:46:45] Can I add something to the resempi?

[00:46:48] Well, yeah. But then the other thing Alf. The VA is going to want to do three fusions. The other problem you're going to have is it's not just the discs. When you're sitting, when there's that kind of impact, it'll cause disk bulges. But find out, is his pain worse when he bends forward or when he bends back. My money is that a bunch of these pain generators into the, especially the ones down the back of the leg to the knee. There's going to be facets. So unless they're planning on doing a 360 fusion, the disc surgery is not going to help that much.

[00:47:32] Go. Yes to everything that you said. Of course. But please. You know when you're working on a concept or you have a question when you're in class and then someone else asks a question, you're like, thank God somebody else said that because that's what I was thinking. So remember when we were working on, like expunging the 58s from the Musculo part. Because we didn't think the 58s worked, but they have a place with viscera. When we had Ben Katholi on, and I'm not sure if you had a chance to watch that back. I was asking him one of my common question is like, what are your favorite A channels and what do you love? And he and I were both doing the same thing with 94 and 142. Trama in the fascia and 294 and fascia. Fascia is innervated.

[00:48:32] Right totally.

[00:48:34] I have been running 94/294 with the fascia for an extended amount of time. Think like 124-type of criteria for 40-minutes on one machine. And the results will make the hair in your arm stand up.

[00:48:54] Seriously.

[00:48:55] I'm serious. So I have a newfound. What we do when we are doing, like scoring in the court and scoring in the dirt and the court that seated kind of flexion movement, I would suggest doing something like that as well, having that patient sitting in very slowly what we call a stacking exercise, really slow flexion. I would suspect that

those vertebral segments are moving in a clunk because these type of patients who are in law enforcement or who are in that sort of field will blow through the stop signs to get to where they need to get to. And so sentimentally, you have to be able to not only get the flexibility in there, but the control of the movement so that they can work through the compression, the adhesions. Well.

[00:49:51] That means you have to get the multifidi on the road of choice working. And they're not going to work until the inflammation and the discs and the facets because they're inhibited.

[00:50:00] For sure, and rightfully so.

[00:50:02] Those muscles are inhibited. So exercise is like step two or three in my world until you get the inflammation down on the disc and the facets. And what you talked about was stacking made me think it's like maybe there should be one unit that's running back to foot, back to front, which is 124/77 on it, and 100.

[00:50:33] Or 94/77 or 294. Like, this is traumatic stuff that happened to like you said, I think if we're looking at the fashion component and the nervous system component, you're absolutely right. The muscles are not going to turn on or let go if they're stabilizing something that is a perceived danger like spine trauma.

[00:50:58] Disc bulges and busted up facets.

[00:51:01] But where I might disagree is I don't think it's treatment three or four. I would do it at one because as you are taking out scarring and you're making change, I don't see a problem with just doing something very gentle as going for facets.

[00:51:19] Activating the micro muscles.

[00:51:21] Absolutely. Yeah, that's what I mean. Patients like this will blow through the stop sign. So the rotators and the multifidi, they've checked out. Transverse abdominals not participating. So these patients will come in with those erectors spinning group. Longissimus are going to be like rocks because the QL is going to be. The psoas is going to need. All those muscles. That should be micro stabilizers are now macro

stabilizers. So my opinion, the sooner you can, just start to get motor recruited, it's not even an exercise. It's just, it's a simple stacking. It's just. Just reintroducing small movements in a safe environment.

[00:52:01] Well, and that's why the only piece of real rehab equipment I have in my office is a Pilates reformer. Yeah, because they lay down, they've not loaded gravity. And when you slide, you're using your legs. But in order to stabilize your core, as you extend the little muscles go, oh.

[00:52:23] Right.

[00:52:23] Not so bad. And all actually, all Alf had to say was foremost former special forces elite. So I just.

[00:52:32] Okay, okay, yeah. Enough.

[00:52:35] That's. Okay then you know. And Alf, they only think his low back is the problem. So the low back is the obvious one. But if you don't need 40/10 on him, I'll buy you lunch.

[00:52:55] He wrote at the end, too, it's worse with the extension, of course, because it's the compression.

[00:53:00] With police, worse with extension. So they're going to do surgery because of the neuropathic pain. But if you look at where he actually has pain, if they operate on the discs, they're going to make it worse because they miss the pain generators. And the pain generators are the sacks. Yeah. If he's in a helicopter crash while he's strapped in. The facets, the disk gets compressed because of the verticality. But if you look at the mechanics and how they're sitting, they're sitting in extension and the four joints get smashed. Seeing him once a week is fine. But Alf, do you have four machines? Because I don't know how to do this without four or five on at once. It's like, how do you get so much done in an hour? Well, you treat everything at one time, right?

[00:54:06] Somebody had asked something about like disc versus facet. You don't need a fancy. Ask the patient just off the bat, does it hurt more when you bend down to touch

your toes or put on something, or when you come up from that bent position to extension and they'll tell you right away it's that extension.

[00:54:27] Or the other thing is that they'll say, I don't know, and that's because they avoid the thing that makes them worse. So I have them stand up.

[00:54:37] Right.

[00:54:38] Lean forward. Oh, that makes it better. Lean back. Ow, okay it's the facets.

[00:54:45] One more thing Alf had written just here. He's trying to avoid surgery. He knows that will worsen in other parts of the spine. Alf has two machines, but he's going to spend more time with them. Perfect. Two is better than one.

[00:54:57] I look at what I do now. And I was talking to this same patient about what it was like when I had one blue box, and then I got two blue boxes, and now I've got five machines on one patient every single freaking time. And it's not because the machines are cheap, it's because they pay for themselves. And so the. My partner in the clinic. She was she's a chiropractor. They're used to getting paid \$40 a visit. And so she gets really creeped out by having to charge somebody \$150 a visit. I said, you've got four machines in there. You're doing four months worth of work in a month. You just save them \$20,000 and a bunch of rehab. And you're feeling wiggly about charging him \$150 an hour. Get a grip. It's like. And the machines end up paying themselves. Paying for themselves, even if you're stuck in an insurance practice, by the way. The people. Sorry, the people that feel overwhelmed and that at this point, that should be almost everybody that's listening because of what we've done in the last. It's 55 minutes already. Okay, fine. Come to the practicums. The practicum trainings are not just for people who've taken the course. You can pay for the practicum training. I don't know what it is for somebody that took the full course a long time ago, but come to the two-day practicum and all of this is the Practicums have I don't care. When you took the course, the practicums are different than they were even two years ago. So you get refreshed and renewed and the logic of it begins to make more sense. Yes. And then. And then there's mileage.

[00:57:02] Right and flexibility of thinking because as much mileage and you have more mileage than any of us in this. You're never stuck on. This is the only way to do this. I mean, you listen to people that said, listen, I did this and this happened and you're the first one to go. I wonder why that was. And we dissect it and we troubleshoot it and we come up with concepts. And then it works and it works and it works and it works and then it doesn't.

[00:57:32] The only difference between me and everybody else that does FSM is I've made more mistakes than anybody. You can't possibly make a mistake that I haven't made. So that's kind of how we've ended up. I'm not trying to sell machines. It's because each part of this as we've learned. So to run the frequencies that you need and do it all at one time to cover the physical damage, the neurological system, and coordinate that with movement. So before the lady with the achilles tendonitis. She had achilles tendonitis because her femur was internally rotated, because she had adhesions between her pectineus and her knee that had her femur internally rotated. What's that going to do to your achilles? Right. So easy to get suckered into treating the achilles without saying. She said, Well, I have this hip pain, but it was in this thigh pain, but it resolved. It's all better now. And I'm thinking to myself, I don't think so. Yeah. So. Right. So you feel it and then believe what you feel. And to be able to treat it all at one time. That's the most fun you can have with your clothes on.

[00:59:14] Before we end. I end with a quote and I want to talk about my quote because I have all these quotes and then I have all these themes and I try to piece them together, but I never match the quote with the theme. But I did today, and it was really strange. So my quote today was or is gratitude and attitude are not challenges. They are choices.

[00:59:41] Oh, do that again. I just got goosebumps everywhere.

[00:59:45] Gratitude and attitude are not challenges. They are choices.

[00:59:50] They are. I choose to ignore the bad stuff.

[00:59:58] Right. And, you know, with that one person that had written in about feeling overwhelmed that there's so many things outside this is. Be grateful that you have

choices, right? Don't have an attitude about it. Be grateful that you have choices. And then going back to the flexibility. Don't get attached to your ideas. Don't. You can't have an ego. Right. Your hypothesis will be wrong. You will have to be flexible. Whether or not you practice with FSM or not. You're not going to be right 100% of the time. All patients will not heal in the same time chunks that your textbook said it would. That just doesn't happen in the real world.

[01:00:44] Healing is not linear. The other the other thing. Speaking of scope of practice. That the section of the core where we talk about the visceral causes of myofascial pain. Are you treating? Are you treating the ureter or the kidney? No, no. What are those frequencies for? They take away trigger points in the psoas. No, but what are the frequencies do? They take away trigger points in the psoas? That's the only thing you can prove. The fact that in our world, the I'm treating. That's the other thing I did this week that was so much fun. Treating adhesions in the ureter, adhesions in the kidney. And some chiropractor whom I dearly love, one of my favorite people on the planet, was digging into this guy's psoas and his hip muscles. And his hip hurts because it's so as is so tight, it jams the hip into the capsule and wears it out. So. It is outside my scope to treat anybody's kidney, kidney, fat pad or ureter. That's not my scope. Right. Even if you're a massage therapist. Totally. What are you doing? I'm treating trigger points on the psoas. How are you doing that? Well, this is frequency 13 on A and 60 on B. That seems to be work working really well to lengthen the psoas and that makes hip motion better. But then you also have the the other thing that releases the quadratus lumborum is 13 on A and 23 and B, what's that for an insurance or your scope? People ask you, what's that for? Well, it releases the tension in the quadratus lumborum. But what's what are those numbers do they release tightness in the quadratus lumborum. That's all we can say. That's not outside your scope.

[01:03:06] No, exactly.

[01:03:07] That's like trust the force, Luke.

[01:03:13] Fastest hour of the week has concluded.

[01:03:18] Okay, fine. And I love your quote. It is. What people don't understand it is, is that it is a choice. I feel this way. Okay. What are you paying to look at the news and

look at this? It's like and I said to somebody this week, I don't look at it. Absolutely. I refuse. I just don't. What is directly in front of you. So when I was doing Outward Bound the first time, I was 28 and I did the course in Colorado because I am afraid of heights. Like. Yes. That afraid of heights and. So a rock climbing and you're completely physically safe. You've got a rope. You've got this. You got that. And I'm halfway up this rock and I'm going, This is not good. I'm freaking out here. And then the voice in my head said, Where are your feet? Well, on these great big rock hole footholds, where your hands, they're on handholds. And you move one hand and you always have three points of contact and you've got a rope. Physically, you are completely safe. So you have a choice. Then there was the really scary part. We're walking across a snow face that is 45 degrees this way. And there's six people in front of me and seven people behind me, and we're all roped together. We all have ice axes. And I looked out and there was nothing between me and Utah. I'm in southern Colorado. There is nothing but air between me and Utah. And there's this fanatic desire to curl up in a ball on the snow and clutch it with my fingers. And I couldn't do that because there's six people and right. So I have two. And then I made the choice to look down at my feet. What's in front of you. Snow. It's flat. There's nothing scary about. Putting one foot in front of another. And I chose to pay attention to that. And that's how you overcome the really scary stuff. Yeah, it is. Said that again. Say your quote again.

[01:06:25] It's a good one. It is. Gratitude and attitude are not challenges they are choices.

[01:06:33] I choose flexibility. Yes, you can.

[01:06:43] And I am grateful for that choice.

[01:06:47] Amen. You can have an ego. You just have to keep it in a box in the closet. And you know, leave it there for certain periods of time.

[01:06:58] Like when the patient, the impossible patient leaves and you close the door and you turn around and go. Just really quietly as you're changing the table for the next impossible patient to come in. I just did that. I just that.

[01:07:12] And then you look at the patient, the next impossible patient who walks in and you take off your glasses and you look them in the eye and you say, nothing you have scares me. And they say. I've never heard a doctor say that. It's like nothing you have scares me. And honestly, that ends up being a choice. Yeah. And that I am just fine sending them to a Doctor that's going to prescribe prism glasses. One patient this week I sent him to an ENT that I know who understands endolymphatic hydrops. That's outside my scope. I can't do what this guy does. He needs drugs. That's okay. It's just so. I know it can't. There you go. I have to shut up now.

[01:08:19] Yes, you do.

[01:08:21] Your quote is going to be the title of this webinar, right? Did you write it down?

[01:08:26] Gratitude and attitude are choices.

[01:08:29] Flexibility she said that was the theme.

[01:08:32] When we started, so we had to be flexible with the title.

[01:08:35] Kevin There you go. If you if you send it to me, I'll have my graphics guy turn it into a poster.

[01:08:43] I love that.

[01:08:44] Two posters this week and I'll forget that. I'll tell it to you next week.

[01:08:52] Okay.

[01:08:54] Yay!

[01:08:55] I love it. Thank you. Thanks, everybody, for coming. Thanks, everybody. Same time, same place next week.

[01:09:01] Thank you for keeping the train on the tracks. Choo choo.

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